Feasibility of a Single-Payer Health Plan for Maine: Results from the Maine Microsimulation Model

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Overview

- Creating the base case
- Single payer plan designs
- Base case projections
- Single payer projections
- Sensitivity tests
- Conclusions, caveats and research needs

Creating the Base Case

- Maine CPS sample
  - Adjust to "borrow power" from the US sample
  - Categorize Maine population into 18,240 cells
    - Sources and combinations of insurance
    - Age and gender
    - Family income
    - Firm size (of insurance reference person)
    - Region
  - Adjust for CPS undercount of MaineCare

Creating the Base Case

- Cost of Maine's current system of financing health care
  - Insured expenditures for health care services
    - Privately insured
    - Medicare
    - MaineCare
  - Out of pocket expenditures
  - Administrative cost (health plans and providers)
  - Uninsured and uncompensated care

Single Payer Plans

- Alternative plan designs
  - MaineCare benefit (Plan 1)
  - Broad coverage with copayments (Plan 2)
    - Above 200 % FPL (A)
    - Above 300 % FPL (B)
    - Above 400 % FPL (C)
  - Broad coverage with coinsurance (Plans 3A, 3B, 3C)

Base Case Projections

- As Maine's population ages
  - Medicare becomes a larger payer
  - More elderly rely on Medicare alone
  - More Mainers become eligible for MaineCare
- Nearly 96 thousand Mainers will be uninsured in 2004 – about 7.4 percent of the population.

Base Case Projections

- Total spending will reach $8.4 in 2004, of which employers will pay $2.8 billion.
- Consumers will spend about 14 percent of total health care costs.
- Per capita health care costs will reach $5,567 in 2004 and $7,323 in 2008.
- Uncompensated care will reach $175 million in 2004 and $217 million in 2008, or 2% percent of total spending.

Single Payer Projections

- Total spending under a single-payer system varies between 98% to 114% of base case spending in 2004.
- Consumer out of pocket costs decline to 1-5 percent of total health care spending.
- With constraints on health care cost growth, the net cost of a single-payer system varies from 92 percent and 107 percent of base case spending in 2008.

Financing a Single Payer System

- Reduced out of pocket cost
- Employer, employee and individual relief from premiums
- Government maintenance of effort
- Retention of private employer contributions = “breakeven” rate on total payroll (6.6%-6.8%)
- Net cost of a single payer system

Single Payer Projections

- Net of baseline public-sector purchasing in Maine, a single payer system must finance 49-52% of total health care costs – $3.2 - $4.9 billion in 2004.
- By 2008, the net cost of a single payer system declines to 36-48% of total health care costs.

Alternative Financing Strategies

- Payroll tax financing
  - Break even rate on payroll
  - Additional rate on payroll
- Diversified financing
  - Payroll
  - General revenue sources
  - Other

Single Payer Projections

- Economic impact
  - Job growth in health care delivery
  - Decline in administrative jobs
  - Net change in employment is small and varies by plan design (-5,000 - +3,000 jobs in 2004)

Achieving 5% Savings

- None of the plan designs estimated achieve 5% savings by 2004
- Plan 3A achieves nearly 8 percent savings by 2008 (but less than 2% by 2004)
- Other options:
  - Increase cost sharing
  - Retain managed care
  - Constraints on cost growth

Sensitivity of Estimates to Key Assumptions

Seventeen scenarios:

- Level of managed care
  - High vs. low
- Level of administrative cost savings
  - Low, intermediate, high
- Degree of constraint on cost growth
  - Low, intermediate, high

Best and Worst-Case Scenarios

- Plausible best case: high managed care, moderate administrative saving, moderate constraint on cost growth
- Worst case: low managed care, low administrative saving, low constraint on cost growth

Sensitivity Results: Total Spending

	2004	2008
Plan 1		
Plausible best case	$9.3 billion (111%)	$11.5 billion (105%)
Worst case	$9.9 billion (118%)	$12.5 billion (114%)
Plan 3A		
Plausible best case	$8.0 billion (96%)	$9.9 billion (90%)
Worst case	$8.5 billion (102%)	$10.7 billion (98%)

Sensitivity Results: Financing as a Percent of Payroll

	2004 Uncertainty about administrative savings	2008 Uncertainty about cost growth
Plan 1		
Intermediate case	+10% (Total: 17%)	+9% (16%)
Worst case	+11% (18%)	+11% (18%)
Plan 3A		
Intermediate case	4.5% (11%)	+4% (10%)
Worst case	6% (12%)	+5% (11%)

Conclusions

- Single payer is feasible in Maine, but very low cost sharing
  - Makes a single payer system more costly
  - Maximizes the difficulty of financing
- Costs are moderately sensitive to use of managed care, administrative savings, and constraint on cost growth
- Financing needs are significant, but less sensitive to administrative savings and cost growth than might expected

Caveats and Research Needs

- Economic and financing estimates are not integrated
- Distributional impacts are not estimated
- Estimates might be improved by:
  - Improved population data
  - Clearer understanding of insurer and provider administrative cost
  - Clearer understanding of access to care and population productivity
  - More detailed analysis of workforce needs (employment and training) and worker displacement